Jontell Limited

Carr Hall Care Home

Inspection report

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09 October 2017

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out on 08 and 11 September 2017 and was unannounced on the first day. Following our inspection visit in September 2017, we took action to restrict new admissions and asked the provider to complete an action plan on what actions they would take to address the concerns we found. A further unannounced visit was undertaken on the 09 October, 2017 to review the actions that the provider had taken.

We last inspected Carr Hall Care Home in July 2016. At that inspection, we found that people's safety was being compromised in a number of areas. This included how people's medicines were managed, managing risk of fire and infection, a lack of person centred care, safe care and treatment. There was also a failure to ensure staff received appropriate support, training, supervision and appraisal, a failure to undertake robust employment checks and a failure to provide good governance. Following that inspection the provider sent us an action plan detailing the improvements they would make in the home.

During this inspection we reviewed actions the provider told us they had taken since our last inspection to gain compliance against the breaches of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified.

During this inspection we found the governance arrangements in the home were not effective enough to rectify the breaches found at the previous inspection. Insufficient improvements had been made and the provider had not followed the action plan and undertakings that they provided us after July 2016 inspection. The provider was still in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person centred care, safe care and treatment, staffing, fit and proper persons and good governance.

We found that there had been a further deterioration in the quality of care in other areas, which meant the provider was in breach of a further three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to seeking consent, maintaining the premises and equipment and failure to notify Care Quality Commission of significant events that affected the smooth running of the service. This meant that risks to people had increased.

Enforcement action was taken by the Commission in light of the significant work needed within the home to improve the quality and safety of the service being provided. The enforcement action was to prevent the service provider admitting new people to the home whilst those changes took place.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of

inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Carr Hall care home is registered to provide accommodation and personal care for up to 23 who are older people, have a physical disability or people living with a dementia. Nursing care is not provided. All rooms were of single occupancy and of these six were ensuite. Bedrooms were located across two floors of the home. At the time of our inspection there were 20 people who lived at the home.

The service was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's medicines had not been managed safely. Guidance for safe management of medicines had not been followed which included secure storage of medicines and a lack of robust recording for topical creams and thickening powders. The systems in place to monitor the use of medicines were not effective and regular medicines audits had not been conducted. Our visit on the 09 October 2017 identified that support had been provided by the local Clinical Commissioning Group and issues we identified had started to be addressed. An action plan had been provided by the medicines management team. The registered manager had started to address some of the concerns found however no formal medicines audits had been undertaken.

Risks to people were not managed in a safe way. People were offered an inconsistent approach following head related injuries as there was no clear guidance in place for staff to follow. We saw no evidence to demonstrate that action had been taken to seek advice from medical professionals after people had incurred head injuries. People could not be assured that they would receive appropriate support following a fall. During our visit of on 09 October we found that a falls management policy had been put in place and up to date falls protocols had been introduced and staff had started to follow these. However this needed time to be embedded to ensure consistence.

We looked at the risk assessments in place for people who used the service and these included skin and pressure area care, falls, moving and handling, mobility and nutrition. However we found shortfalls in other areas of risk management, including a failure to provide staff that were first aid trained. The risk assessments had not been completed and reviewed consistently when people's needs had changed. We found similar inconsistencies with care plans.

When potential safeguarding incidents had been recorded we did not see these had been reported in line with local safeguarding procedures. There was safeguarding policy however this was not robust and did not reflect current practice and legislation. A significant number of staff had not received training in

safeguarding adults. However staff we spoke with showed awareness of signs of abuse and what actions to take. During our visit of on 09 October we found that staff had received first aid training and risk assessments for two people at risk of choking had been updated and those at risk of falls had been referred to relevant professionals. However a significant number of care records were yet to be reviewed. The local authority safeguarding team had visited the home and were reviewing risks in the service.

People were not effectively protected in the event of a fire. Building fire risk assessments and Personal Emergency Evacuation Plans (PEEPS) were in place. However no fire drills had been undertaken since February 2014. We had previously asked the provider to take action about this during our inspection in July 2016. At this inspection in September 2017 we found there were obstructions on fire exits and fire doors had been wedged. We reported our findings to the service to the local fire safety department. During our visit of on 09 October we found that a fire safety inspection had been carried out by the fire safety officers. The fire safety officers found several concerns including shortfalls in the fire risk assessment, the fire doors and poor fire safety practices. They requested the provider to take action. On our visit on 09 October we found the provider had started to address some of the concerns however these had not been completed.

The provider had not adequately maintained and repaired the premises in a timely manner. We found the roof had been leaking for approximately 19 months. Attempts to repair had been made however we expected this to have been rectified. The water pressure in some rooms was very low preventing people from having access to hot water. Equipment had been maintained and serviced in line with regulations and manufacturer's recommendations. Infection control measures were not robust and required further improvements. The premises had not been adapted to ensure that they were dementia friendly. During our visit of on 09 October we found the roof had not been fixed however the provider had ordered materials required to fix the roof. They informed us they had been a delay with the delivery. An electrician had assessed the risk of water ingestion in the electric systems and isolated the light fittings in the area affected. A specialist had reviewed the concerns with water pressure and ongoing investigations on how to rectify this were ongoing.

Safe recruitment practices were not always followed to help ensure only suitable people worked in the home. Guidance on safe recruitment had not always been followed.

People using the service had access to healthcare professionals as required, to meet their needs. We found that people's health care needs were assessed on admission to the service to ensure the home was able to meet their assessed needs. However, this was not always consistent as some people did not have pre-admission assessments in their records.

Care records were written in a person centred manner however they were not always reviewed to demonstrate changes in people's conditions or after significant events. People received adequate food and drinks throughout the day ensuring their nutritional needs were met. Food was fortified to support those at risk of losing weight. However, risks of weight loss were not managed in a robust manner because weight monitoring was inconsistent and not always carried out. During our visit of on 09 October we found one care record had been reviewed and the registered manager and the provider informed us they were expecting to review one record per week. This meant that people would not be assured they would receive the right care as their records did not reflect their needs. We found new weighing scales had been purchased and people had been weighed and referred to dieticians where required.

During the inspection we observed staff responding to people's needs in a timely manner and there were always staff available for people when they asked for assistance. We observed staff communicating with people in a kind and respectful way. People told us staff respected their privacy and dignity and encouraged

them to be independent.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; however the policies and systems in the service did not support this practice.

We found care planning was not always done in line with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All care files we checked did not contain records to show people's consent to care and treatment, mental capacity assessment for decisions to receive care. We identified people who required DoLS authorisations who had not been considered for authorisation. The provider had not made arrangements to improve staff's knowledge and practice in relation to mental capacity and supporting people to make decisions about their care and treatment. We had made a recommendation on this in July 2016.

Since our last inspection in July 2016 the provider had not made improvements in relation to ensuring that there was the right mix of skills and competencies of staff. Care staff had not received adequate training and development, supervision and appraisals. Staff were not competence checked in various areas of care.

There were significant shortfalls to training in areas such as fire safety, moving and handling, safeguarding, mental capacity and health and safety. Four care staff had not received any training. During our visit of on 09 October we found the provider had arranged mental capacity training for care staff. However our conversation with the registered manager showed a continued lack of understanding in the application of MCA principles in practice including how to apply for DoLS authorisations. We found further work was required to ensure the training and knowledge could be imbedded in practice. We also found only one DoLS application had been submitted by the registered manager.

On our visit on 09 October we found the provider had arranged training from an accredited trainer who had visited and delivered training in mental capacity, moving and handling and first aid. There was further training booked for all areas that the provider deemed necessary for the role. All staff had now been trained in moving and handling. However all training needed time to be fully imbedded in practice.

People were supported with meaningful daytime activities. However, this was not consistent and improvements were required. There was one care staff member who also worked as an activities co-ordinator.

Systems for governance and leadership in the home were not robust. The provider had failed to address all the breaches of regulation found in July 2016 and the service was found to have deteriorated with three further breaches of regulations. They had failed to provide staff with appropriate, support, training and professional development. They had failed to meet their action plan and the obligations they made after the inspection in July 2016. Since the last inspection the provider had not been responsive and proactive in improving the systems used in the monitoring, assessing and improving the quality of the care and treatment for people living at Carr Hall Care Home.

The systems designed to assess, monitor and improve the service were inadequate. There were significant shortfalls in the quality assurance and auditing processes in the service. Matters needing attention had not always been identified and addressed in a timely manner. This meant the provider had not identified risks to make sure the service ran smoothly.

We found that leaders in the service did not have adequate knowledge of the Health and Social Care regulations and how to ensure compliance. Following our inspection visits on 08 and 11 September the

provider acquired services from a consultant to support the registered manager in the home with governance. During our visit of on 09 October we checked how the registered manager was being supported by the consultant. They informed us that the support was being provided via telephone and email. We found the provider's system for checking compliance on the registered manager had not improved. We could not be assured that shortfalls and breaches of regulation would be addressed robustly and timely to ensure care was provided safely.

All staff we spoke with told us they enjoyed their work and wanted to do their best to enhance the experience of people living at the home. People who used the service felt they received a good service and spoke highly of their staff. They told us the staff were kind, caring and respectful. Many people appreciated having their privacy respected and their independence supported.

There was a business contingency plan to demonstrate how the provider had planned for unplanned eventualities which may have an impact on the delivery of regulated activities.

The provider was not meeting their registration requirements. They did not send notifications to CQC for notifiable incidents, such as serious incidents and significant events that affected the smooth delivery of services. During our visit of on 09 October we found two notifications had been submitted to CQC.

We found instances where the provider had not worked in line with their own organisational policies. This included recruitment of staff, staff supervision, care planning, mental capacity, medicines and providing adequate levels of staff. The policies in the service were not up to date and not in line with current legislation or best practice. During our visit of on 09 October we found the provider had purchased a set of new up to date policies. They had started to introduce these to care staff however this needed time to ensure staff could embrace the changes and new ways of working.

We found the service had a policy on how people could raise complaints about care and treatment. No complaints had been received at the time of our inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

People told us they felt safe, relatives and professionals also felt people were kept safe.

People's medicines were not managed in accordance with safe procedures. Staff had not always been given guidance on best practice in safe management of medicines.

Risks to the health, safety and wellbeing of people who used the service were not always adequately assessed and appropriately managed. Risks in the premises were not adequately and timely resolved.

Risks of fire had not been adequately managed. Faults to the premises had not been rectified and fixed in a timely manner.

Safe recruitment procedures were not always followed.

There was a safeguarding policy and a whistle blowing policy.

Staff were not always aware of their duty and responsibility to protect people from abuse. Safeguarding concerns were not reported to the local authority.

Is the service effective?

Inadequate

The service was not effective

There were significant shortfalls in staff training. Staff had not received adequate training. Supervision and appraisal had not been undertaken for care staff.

People's mental capacity was not assessed where appropriate and best interests' decisions had not been recorded. Appropriate applications were not submitted to the local authority where people needed to be deprived of their liberty to keep them safe.

People were supported to have sufficient to eat and drink and to maintain a balanced diet.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives told us staff were caring. Staff knew people at the home well and treated them with kindness and respect.

People told us staff respected their privacy and dignity and we saw examples of this during our inspection.

People told us they were encouraged to be independent. We noted that equipment was available which supported people to be as independent as possible.

Care files were not always updated to reflect people's needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care and support plans were written in a person centred manner however they were not always updated.

People were not always provided with a range of appropriate social activities to provide them with stimulation. The premises had not been adapted in a dementia friendly manner.

There were processes for supporting people when they moved between services.

People had access to information about how to complain.

Is the service well-led?

Inadequate

The service was not well-led

Comments from staff and people about the manager were positive. They told us there was a open culture.

There was lack of robust leadership and governance systems. The provider had not demonstrated accountability for improving the service and meeting regulations.

Concerns from previous inspection had not been addressed and action plans were not followed to ensure compliance. Concerns about the quality of the service were not addressed timely.

Systems for assessing and monitoring the quality of the service

were inadequate not effectively implemented to improve the care and treatment people received.

Staff were not adequately supported to ensure they were fit to do the job they were employed to do safely.

Policies and procedure in the home were not robust and up to date.

Carr Hall Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 08 and 11 September 2017, and on 09 October 2017 and the first day and 09 October were unannounced. The inspection team consisted of one adult social care inspector, one assistant inspector and one expert by experience who had experience in the care of an adult living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We had asked the provider to complete a Provider Information Return (PIR) prior to our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They completed the PIR which we reviewed and took into account when we made the judgements in this report.

Before the inspection we gained feedback from health and social care professionals who visited the service. We also reviewed the information we held about the service and the provider. This included safeguarding alerts and statutory notifications sent to us by the registered provider, about significant incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We reviewed information from the local commissioning group and the local authority. We also looked at information that had been shared with us from other professionals and comments and feedback that we had received from staff, relatives and visitors of people who lived at Carr Hall Care Home.

During the inspection we spoke with 10 people who lived at the service and two visitors. We spoke with five care staff, maintenance staff, the nominated individual, the registered manager and two directors from the company that operate the service. We observed staff providing care and support to people over the two days of the inspection and reviewed in detail the care records of six people who lived at the home.

We carried out observations of staff interactions, walked around the building to see if it was safe and clean for people who lived there. We also looked at service records including four staff recruitment files, supervision and training records, policies and procedures, complaints and compliments records, records of quality and safety audits completed and fire safety and environmental health records.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection of Carr Hall Care Home in July 2016, we found there was a failure to ensure that people's medicines were managed safely, and a failure to provide safe care and treatment. There was a failure to ensure staff received appropriate support, training and professional development and a lack of robust infection control measures in place at the home. There was also a lack of robust risk monitoring and management, a lack of reporting incidents or concern under safeguarding procedures. We also found there were failings in implementing effective plans for emergency and contingency planning and a failure to undertake robust safe staff recruitment practices.

These were multiple breaches of Regulation 12 and Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvement had been made in respect of Personal Emergency Evacuation Plans (PEEP's) however a significant amount of all the other necessary improvements had not been made.

During this inspection we reviewed requirements outlined in the homes action plan sent to us in December 2016 following the inspection of the service. We reviewed compliance against regulations 12, and 19 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014.

We found that no improvements had been made in respect of safe recruitment of care staff. We found no significant improvements were made to the management of risks to people receiving care, safe management of medicines, infection control management, reporting incidents to safeguarding, or staff training in safeguarding, fire and health and safety. We found further concerns in relation to the support that people received after experiencing falls and involving head injuries. We found there were continuing concerns that the provider had not met the required standards.

At the last inspection in July 2016, there were a number of issues relating to risk management which breached Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. At this inspection we looked at how people were supported to reduce the risk of harm and injuries. Staff did not know how to effectively keep people safe and how to recognise safeguarding concerns. They had not received accredited or valid training in safeguarding adults. Policies and procedures for people to raise concerns about their own care and treatment were in place. However, these were not up to date and had not been followed robustly. For example, we found incidents that required to be reported to the local safeguarding team for investigation which the registered provider had not acted on in line with local and national safeguarding procedures.

We looked at how accidents, falls and near misses were managed. We found accident and incidents analysis was carried out however this was not robust or undertaken consistently in order to ensure lessons were learnt from the incidents. The home had recorded falls, accidents and incidents. We found processes for the reporting and recording of accidents /incidents had been implemented but that staff had not always recorded the support they had provided people after the incidents such as post falls observations.

We found records which showed three people had suffered serious unexplained injuries; which we found to have not been reported to the local safeguarding authority or the Care Quality Commission. This lack of reporting meant people could not be assured the registered provider and the staff would raise safeguarding concerns to allow independent investigations by relevant authorities. Five accident records that we reviewed showed that people were not adequately supported. We saw that support had been sought from emergency services and health professionals in some instances however, this was not consistent as we found five instances where staff did not seek guidance from medical professionals after people suffered unwitnessed head injuries.

Risk assessments had been undertaken in keys areas of people's care such as nutrition, skin integrity and moving and handling as well as behaviours that could pose a risk to self and others. However; this was not consistently reviewed on a regular basis or when people's care needs had changed. For example we found one person has suffered significant injuries that were unexplained. Although care staff had ensured this person received medical attention, they did not review and update their care plan or risk assessments to demonstrate the change in risks and any changes to measures that were required to minimise the risks to this person's personal safety. Immediately after the inspection visit on 11 September 2017 we requested the provider to send us an action plan on how they were going to address the shortfalls above.

People were exposed to risks of choking. This was because the records of thickeners used to thicken fluids for people with swallowing problems were not clearly recorded when they had been used. Information was available to care staff about how to use them for individual people but the records did not demonstrate when they were being given so we could not be sure they were being handled safely. Two people had been identified to be at risk of choking however the risks had not been effectively managed. One person's care record did not give clear guidance to staff on how much to thickener to add to the person's drinks. We prompted the registered manager to take immediate action.

During our visit on 09 October 2017 we looked to see if any changes had been made and found that one care record had been reviewed and referrals made to Speech and Language Therapist. New guidance had been provided by the professionals and staff had started to follow it. The second person had been reviewed and changes made to how they were supported however the new guidance and changes had not been added to the person's care records which had been last updated in 2013. We prompted the registered manager and staff to amend the care file on the day. This would ensure that staff have the correct and up to date guidance.

During our visit on 09 October we checked the actions that the provider had undertaken. We found they had started to put actions in place to ensure risks were reduced. For example we found that they had purchased new falls policies and procedures, staff had signed to confirm that they had read the policies. Pathways for contacting medical support after falls were in place and on display in the home. We found the local safeguarding board protocols for reporting significant incidents in the home were in place however the registered manager was not aware of the existence of the file which we found and had already been in the home but not followed. We observed two falls had occurred since our last visit on 11 September and staff had followed the new procedure appropriately. Although some work had been started in relation to managing these risks we found this was still at the early stages and not fully embedded in within the staff team.

In another example we found one person living at the home who had lost three kilograms in weight in one month. There was no recorded evidence in the care record of what staff were doing about this and the care record was not reviewed nor was the person weighed the following month. This meant that the provider had

not acted on the identified risk and take appropriate action to reduce any further deterioration. We reported all concerns above to the local authority safeguarding team immediately after the inspection. During our visit on 09 October we found the registered provider had purchased new weighing scales and the person had been weighed.

There was an overall fire risk assessment for the service in place. We saw there were clear notices within the premises for fire procedures. We found fire safety equipment had been serviced in line with related regulations. Fire alarms had been tested. However we found shortfalls in fire safety practices in the service. Fire evacuation drills had not been undertaken regularly to ensure staff and people were familiar with what to do in the event of a fire. The last fire drill had been undertaken in February 2014. We had identified this shortfall in July 2016 and informed the provider to resolve this however this had not been done. The provider's own policy stated that fire drills should be undertaken every two months. The provider had failed to follow their own policy. We also found the fire policy was brief and did not reflect current practices and legislation. Following the inspection we received confirmation from provider that fire drills had been undertaken and that they had acquired a new fire policy which was more up to date and provided adequate guidance to staff.

During the first day of the inspection we observed two fire exits were obstructed by chairs. This would delay the quick and safe evacuation of people in the event of a fire. We found the provider had not provided care staff with accredited and valid fire safety training. We found similar concerns in July 2016. This had not been addressed. Following the inspection the provider sent us information demonstrating that they had booked training for all staff and this was taking place immediately after the inspection. In addition we referred the provider to the local fire authority who subsequently visited the service. They informed us that they found shortfalls in various areas including the fire risk assessment which was deemed insufficient, fire doors with missing intumescent seals, lack of door guards, and poor fire safety practices. They requested the provider to take action to resolve the shortfalls.

During our visit on 09 October 2017 we found the provider had started to undertake some of the work that was required in relations to the fire safety shortfalls. However there was more work that needed to be completed to ensure all the faults were resolved. For example not all doors had been fitted with intumescent seals. Intumescent seals fitted on doors and are designed to expand under heat, and fill the gaps between the door leaf and frame, thereby preventing the passage of smoke and fire to other parts or compartments of the building. We also found fire safety training had not been completed however had been booked for January 2018.

We looked at how the service minimised the risk of infections and found some of the staff had undertaken training in infection prevention and control and food hygiene. However they were shortfalls in this training and the validity of the training provided. Staff had completed booklets which had not been marked or verified to ensure they had achieved the required standards to show they were proficient. During our observations we found all but one of the communal toilets did not have pedal operated bins. Where we saw one pedal bin this had been placed in a position where staff could not operate the pedal. We were informed that staff would open the bin with their hands as they wore gloves. This was against recommended guidance and best practice.

We found infection control audits had not been regularly carried out. Records confirmed only one audit had been undertaken in 19 months. There were policies and procedures for the management of risks associated with infections. However we saw the infection control policy in the service was not robust and did not reflect current legislation and best practice.

Following the inspection we referred the service to the infection prevention team at the local authority. They confirmed that would undertake an audit at the home and provide relevant guidance and recommendations. During our inspection on 09 October, we found some pedal operated bins had been purchased. An internal infection control audit was carried out on 06.October however there was no documented action plan on how the issues that had been identified during the audit would be resolved and by whom. We also found hoisting slings were still stored together in one cupboard which may increase the risk of cross contamination. The infection prevention nurse visited during our inspection and carried out an audit of the service. They would share their report with us in due course.

There were failings in the assessment of the risks to the health and safety of service users and measures to mitigate any such risks were not robust. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in July 2016, there were a number of issues relating to medicines which breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These included poor storage and safe keeping of medicines, a lack of monitoring to ensure people took their medicines, and a lack of robust or complete medicine audits. During this inspection we found some improvement had been made however these were not sufficient enough to ensure people's medicines were safely managed.

Medicines were not always stored securely. On the first day of this inspection we found two people's medicines had been left on the office table which people could access. We looked in people's bedrooms and found medicines such as topical creams had not been stored securely. Topical medicines, such as creams, were not accurately recorded after they had been applied; there were body maps and medicine records to record their administration however accurate records of cream administration were not routinely made so we could not be sure that people were having them applied properly.

There was a thermometer for monitoring the room temperature where medicines where stored however the temperature was not recorded. We could not be assured that staff had monitored the temperature to ensure that medicines were not compromised. The registered manager took immediate action and started recording the temperatures during the inspection.

Some of the medicine administration records (MAR's) we inspected had residents photographs and allergy details completed; this helped to prevent medicines being given to the wrong person or to a person with an allergy. Where necessary, we saw two staff signatures on the MAR records where these had been handwritten. Staff who administered medicines had received training in the safe management of medicines. Medicines that are controlled drugs (medicines subject to stricter legal control because they are liable to be misused) were stored and recorded in the right way. We saw evidence of regular balance checks of controlled drugs. However we found ongoing concerns which demonstrated people's medicines had not always been safely managed. We found the provider had not made improvements in relation medicines audits. Only one medicine audit had been undertaken by the registered manager since our last inspection in July 2016. Two other audits had been carried out by an external pharmacist. The lack of regular medicines audits meant that issues and concerns relating to medicines management could not be identified and rectified in a timely manner.

Some people were prescribed medicines to be taken when required. There was no written guidance (PRN protocols), in place to guide care staff how to administer these medicines or details of the time and amount to be given. We asked a registered manager about the lack PRN protocols and they showed us the blank records that had not been completed. Some medicines were prescribed with a variable dose but there was no information to guide staff of what dose to give and when. This meant people may not be given the right

dose of their medication.

During our visit on 09 October 2017 we found the local clinical commissioning group (CCG) had visited the service to review how people's medicines were being managed. We also checked to see if staff had received relevant training. We found staff had received medicines management training. An action plan had been provided by the medicines management team from the CCG however this had not been completed.

The registered manager had also introduced PRN protocols. Temperatures had been monitored and recorded. Records of topical creams had been improved and there was no topical creams visible in people's bedrooms. Two external professionals had visited and checked medicines. However, we found the registered manager had not carried out their own medicines audit and they had not competence check staff who administered medicines following the training. The improvements made were needed to be imbedded in the staff team to ensure consistency.

There were continuing failings in medicines management and administration systems at the home because the provider could not always demonstrate that medicines were being safely handled. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the provider was ensuring that the premises were suitable for the purpose for which they were being used. We found safety checks for gas and electrical appliances had been carried out and servicing of equipment such as the emergency equipment, water temperatures, fire alarm, call bells and electrical systems testing had also been undertaken. This was an improvement from our last inspection in July 2016.

Maintenance checks were being done however they were not robustly identifying faults. There were maintenance records which were meant to be used to report faults and areas of that required improvements. Although staff had reported some of the faults in the home, the maintenance record was not regularly used. This meant that the provider could not systematically track faults in the premises and whether they had been addressed in a timely manner.

During the inspection staff informed us and we observed that a leak had developed in the roof of the home. This had affected one toilet and a storeroom. Staff told us that the roof had been leaking for 12 months. During our inspection in July 2016 there were similar concerns and we had been informed that there were plans to repair the toilet roof. We spoke to the company representative about this who informed us that they had made four attempts to fix the leak however without success. They said they had struggled to find to the appropriate materials to fix the fault however these had now been purchased and they were planning to fix the roof. The issue had not been dealt with in a timely manner which had a potential of exposing people in the home to risks.

We asked the provider to take immediate action to fix the roof. Following our inspection the nominated individual told us they had brought in a contractor to check that the electrical systems in the service remained safe following the roof leak. The service provider sent us confirmation that the roof was going to be fixed and we continued to check with provider that this had been done.

We looked around the premises and found one of the hand wash basin in a bathroom did not have running hot water. One person living at the service told us that they had no hot water in their bedroom hand wash basin for two years. We saw records which demonstrated water temperatures had been checked regularly however two bedrooms had been identified to have low hot water pressure since 2016. However there was no evidence to demonstrate how the provider had attempted to resolve this in a timely manner.

We looked at the premises and found two radiator covers in the lounge were loose and nearly coming off the wall. We looked at the health and safety audits carried out in the home and identified that this had not been picked up. We discussed this with the registered manager who informed us that the premises required new radiators. There was a failure to identify and carry out repairs or faults in a timely manner. We could not be assured that people were cared for in a safe and well maintained environment.

During our visit on 09 October 2017 we found the roof had not yet been repaired. The provider informed us they had purchased materials and there had been a delay in the delivery. An electrician had been asked to inspect whether there had been water ingress in the electrical systems. They had isolated electrical switches in one area. The registered manager informed us that the radiator covers had been fixed, however the covers were loose and easily dislodged. One of the main bathrooms had no hot water. The registered manager informed us they a plumber had visited and they were considering installing a new pump and review the piping to improve water pressure. There was no evidence of when this would be done. In their action plan the provider had informed us that they would now introduce a plan for all remedial work for the following year, however this had not been completed.

The provider had failed to ensure the property was properly maintained, and fit for use. They had failed to ensure that there were regular health and safety risk assessments of the premises (including grounds) and equipment and ensure the findings of the assessments are acted on without delay if improvements are required. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the records of three staff members employed at the service. We saw that all the checks and information required by law had been obtained before staff had been offered employment in the home. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place prior to them being offered employment. However we found in one staff member's recruitment file, the Disclosure and Barring Service (DBS) certificate had been issued for another organisation. The provider had not demonstrated how they were assured that the DBS certificate was still valid. There was no recruitment policy in the service which would guide the provider and the registered manager on how to ensure recruitment practices in the home were safe. We also found none of the files contained copies of photographic identity records as is required by regulations. This meant that we could not be assured that safe recruitment practices had been followed to protect people.

During our visit on 09 October 2017 we found all staff had been asked to bring photographic identify documents however this had not happened. The registered manager advised that they would remind them again. We also found a new recruitment policy had been purchased. We found the provider had not obtained a new DBS for the staff member that we found not to have been DBS checked by the provider. We asked the registered manager to ensure this was done.

The provider had failed to ensure that recruitment procedures were established and operated effectively to ensure that persons employed were of good character. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the risk assessments in place concerning fire safety and how people would be moved in the event of an emergency. We saw the service had contingency plans in place and PEEPS should people who lived at the home ever need to be moved to a safer area in the event of an emergency. These documents gave guidance to care staff on how people needed to be supported in an emergency including the closest fire escape to their room. This was an improvement from our previous inspection in July 2016.

We received positive responses to questions we asked people who lived at Carr Hall Care Home about safety. All the people we spoke with told us that they felt safe in the home. Comments from people included; "I feel safe and I can always call someone on the buzzer. They come as soon as they can and no longer than a few minutes." And; "I'm safe because staff are exceptionally caring."

Relatives and visitors were also positive about the quality of care and people's safety. Comments included: "Yes she's safe, nothing gets past her and she is not likely to fall. I have no concerns and she phones me or I phone her several times a week." Visiting professionals were positive about people's safety and acknowledged that staff acted to maintain people's safety.

We looked at how the provider managed staffing levels and the deployment of staff. People their relatives and staff told us there had been adequate numbers of staff to ensure people's needs were met in a timely manner. We observed staff were responding to people's needs promptly and call bells were being answered quickly when people requested assistance. One person told us, "As far as I'm concerned yes there are enough staff. I pull the cord and they come quite quickly." The registered manager informed us that staffing levels were kept under review and were flexible in response to the needs and requirements of the people using the service. This continuous monitoring of staffing against dependency would be essential when occupancy increased and more staff were needed to meet people's individual needs.

Inadequate

Is the service effective?

Our findings

At our previous inspection of Carr Hall Care Home in July 2016, we found the provider had not taken effective action to ensure that staff received relevant training and supervision. They had also not provided staff with guidance on how to safeguard people who lacked mental capacity. These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made a recommendation in relation to the monitoring of people's weight.

During this inspection in September 2017, we reviewed compliance against regulations 18 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. We found that no improvements had been made in respect of staff training of care staff and the service was in breach. Staff had started to monitor people's weight and taking action where concerns had been found by referring to professionals. However this was not always consistent. We found that the provider had failed to follow their action plan or to make significant improvements in relation to staff training, supervision and development and that this had further deteriorated. They had failed to demonstrate that they had met the requirements of Regulation 18.

At the inspection in July 2016 a significant shortfall in the training that the provider required staff to complete in order to fulfil their roles had been found. The majority of the staff had been offered valid training in relation to moving and handling and safe handling of medicines. At this inspection we saw there was a training matrix in place recording the training that staff had done and what further training they needed. However we found four of the care staff working at the home had not received any training from the provider, including moving and handling. We found people living in the home who required assistance with their mobility using hoists and other aids. This would mean that staff needed to be trained to ensure they were aware of the safe operational procedures and risks associated with moving and handling practice. This meant that people were exposed to risks of injury from staff who were not trained in safe moving and handling practices.

In addition we saw three care staff who had been at the service for more than 6 months had received training in moving and handling only and no other training that the provider had deemed necessary for the role had been provided. Staff informed us they had not been competence tested by senior staff to check they transferred people safely after their moving and handling training. This meant that the provider had failed to show how they had supervised staff to demonstrate they had the required or acceptable levels of competence to carry out their role unsupervised. The registered manager and the nominated individual informed us that untrained staff were always supervised when undertaking moving and handling procedures, however we found this was not sustainable and achievable as the manager and the senior staff could not always be present when care is delivered.

We reviewed the training provided by the service and found the training was not valid and did not meet the standards set by Skills for Care. We found all staff had been provided booklets from an external trainer to read in various areas of care and asked to answer questions. However the question papers completed by staff were not marked by the training provider or an accredited person to verify that staff had passed the subject areas and were proficient. This training arrangement was not sufficient and did not ensure that staff

were provided with adequate training and development.

At our previous inspection we found concerns regarding shortfalls first aid training and health and safety training. The provider informed us that they would take action to rectify this. During this inspection we found some staff had received relevant training to support their role however records identified that nine staff had not received first aid and health and safety training. This lack of training meant that the provider could not be assured that staff would respond appropriately to an emergency or risks involving other staff members or people who lived at the home.

Staff had not received supervision in line with the provider's own policies. The registered manager informed us that they had not undertaken supervisions since January 2017. We spoke to care staff who informed us that had not received supervision for a long time but used to have this regularly. This meant that the provider had not provided staff with supervision to enable them to carry out the duties they are employed to perform. They had also failed to follow their own policies on staff supervision. Staff however, informed us that they could speak to the registered manager regarding their work whenever they had concerns. We looked at records of appraisals and found that none of the staff who had been employed for more than a year had received an appraisal. The lack of these systems meant that there was a lack of oversight of the care staff by the manager. There was no opportunity to receive identify staff training, learning and development needs or to provide formal support for individual staff.

During our visit on 09 October 2017 we found the provider had made arrangements with an accredited trainer and a number of courses had been booked. We found staff had been trained in areas such as moving and handling, fire safety, mental capacity first aid, medicines management. Safeguarding training had not been provided however had been booked. The registered manager informed us they were working to ensure this was prioritised. 14 care staff had received supervision and a calendar was in place for future supervision dates. Although training had been provided we found it needed to be imbedded into the service and there was a significant amount of training that was yet to be provided.

There was a continued failure to ensure that all staff had received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the last inspection July 2016 we found shortfall in staff knowledge and understanding of mental capacity and DoLS.

We checked whether the service was now working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service was not working in line with the key principles of the MCA. Records we looked identified up to seven people living

at the care home who were at risk of being deprived of their liberties because they lived with a dementia and experienced difficulties in communicating their needs or giving consent. These people were not free to leave the care home, lacked mental capacity and were under constant supervision by the staff team for their own safety. However the provider had not sought relevant authorisations from the local authority. These authorisations are required where it had been necessary to restrict the people for their own safety and the measures in place should be as least restrictive as possible.

We found shortfalls in the registered manager's and care staff understanding of their responsibilities under the MCA 2005 legislation. Although staff said they always asked for people's consent before providing care, we found the records to demonstrate whether people's consent was sought, were not completed.

We spoke to the registered provider, the registered manager and care staff in relation to this. There was a lack of knowledge and understanding of MCA principles and how to apply them and staff had not received training in this area. We had found similar concerns in July 2016 and made a recommendation for the provider to review and improve their practices however this had not happened. This meant that people were at risk of having their rights infringed and of unlawful restrictions.

During our inspection visit on 09 October 2017 we found staff had been provided with some training in mental capacity principles however no mental capacity assessments had been completed and there was no consent records for photographs or medicines. One application had been made for DoLS authorisation for one person. We spoke to the registered manager they informed us that they had undertaken the MCA training. However our further conversations with them regarding completion of assessments and DoLS notifications demonstrated that they continued to lack skill and knowledge to undertake assessments. We could not be assured that they would be able to put the training into practice and provide care staff with guidance in the assessment and application of MCA principles in the home.

There was a failure to request deprivation of liberties authorisations from the local authority for people who lacked mental capacity and who received care that included restrictive practice. There was also a failure to seek consent. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We looked at how people's nutrition was managed. We found the provider had suitable arrangements for ensuring people who used the service were protected against the risks of inadequate nutrition and hydration. All of the care plans we looked at contained information on specific dietary needs, preferences and any intolerances. We saw evidence of checks being completed in regard to staff completing dietary intake charts, positional changes. Staff were taking action and ensuring people at risk of losing weight had fortified diets. All the files we checked showed that people had an individual nutritional assessment. However we found people's weight was not regularly monitored or reviewed for changes so that appropriate action could be taken if needed. One person had lost more than four and half kilograms in weight. However their risk assessments or care plan was not reviewed since they had been weighed in June 2017. This meant that staff had not monitored this person's weight to ensure the relevant action was taken if required.

During our inspection in July 2016 we identified one person who had not been weighed as they were unable to weight bear. We checked this during this inspection and found staff had weighed the person however this was not consistent. Records we saw showed that staff had not weighed the person as they could not weight bear. However they had not considered other recognisable alternative ways of checking people's weight such as mid upper arm circumference (MUAC). Mid-Upper Arm Circumference (MUAC) is the circumference of the left upper arm, measured at the mid-point between the tip of the shoulder and the tip of the elbow. It is used for the assessment of nutritional status for people who are bedbound and cannot be weighed using

standard weighing scales. Staff had not received training in nutrition and food safety to help them understand their responsibilities and the risks to people.

At our visit on 09 October we found action had been taken and the person had been weighed and staff had made relevant referrals to other professionals where people were at risk of weight loss. All weight records were up to date.

We observed lunch time experiences during the two days of the inspection. People told us they enjoyed the food and were given a choice of meals and drinks. Comments from people included, "Every lunchtime choice between two meals and if you don't like them they'll do you something else like a chicken kiev." I have my breakfast in my bedroom; my choice is toast and a cup of tea." And; "Meals on the whole are good. Something always homemade for lunch which is two courses - puddings are particularly good. Teatime there's a choice of sandwiches and brown or white bread, cake after." Refreshments and snacks were observed being offered throughout the day. These consisted of a mixture of hot and cold drinks and a variety of biscuits and fruits.

The care plans and records that we looked at showed that in majority of the cases people were being seen by appropriate professionals to meet their needs. For example, referrals had been made to the dietician and the Speech And Language Therapist (SALT).

We looked at how people were supported to maintain good health, access community health care services and receive on going health care support. There were links with the local primary health services and professionals such as district nurses, dieticians, doctors, and community mental health practitioners. These professionals came into the service to offer support whenever they were needed. People we spoke with told us they were able to access health care services as required. Two healthcare professionals we spoke with informed us the home was proactive in referring people for specialist support in a timely manner and that the advice they gave was taken on board.

Requires Improvement

Is the service caring?

Our findings

We spoke with people who lived at Carr Hall Care Home and their relatives about how they felt the staff approached them and cared for people. They told us that staff treated them with "kindness" and "consideration". Comments included; "Champion in here very, very good. Carers are very good", "Overall excellent, kind and caring staff", "Staff are very good, wouldn't grumble about them at all, always pleasant and helpful, always a smiley face rather than a grim one." Comments from visitors and relatives were also positive. The comments included; "Staff that are here are lovely, they're very kind.", "I would say their attitude is helpful and they will do anything to help people."

We looked at how the service supported people to express their views and how people were actively involved in decisions about their care, treatment and support. We saw evidence to support that people had not been actively involved in the planning of their care. Care files did not show how people or their relatives had took part in planning their own care. We spoke to relatives who confirmed they had not been formally involved in reviewing their loved ones' care. They however, informed us they had been kept informed of any changes to their loved ones' care needs.

We observed several caring and appropriate interactions between staff and people who used the service especially when assisting them to sit down or moving around the home. Some staff initiated the interactions easily. For example whilst people were sitting in the dining room waiting for other people sit down, then lunch could be served. We also saw examples of staff giving people their full attention and offering reassurance especially in the downstairs area where people lived with dementia.

We observed that staff provided support to people where and when they needed it. Requests for help were acted on quickly and support with tasks such as moving around the home was provided in a timely manner. People seemed comfortable and relaxed in the home environment. They could move around the home freely and choose where they sat in the lounges and at mealtimes.

We found Carr Hall Care Home to have a friendly and welcoming atmosphere. We observed staff engaging with people in a warm and friendly manner. We also received positive comments about the caring nature of staff from healthcare professionals. One professional told us "Staff are always pleasant and caring when interacting with the residents, a good rapport is often observed between staff and residents during visits."

We saw people were treated with respect and dignity. For example, staff addressed people with their preferred name and spoke in a kind way. In addition to responding to people's requests for support, staff spent time chatting with people and interacting socially. People appeared comfortable in the company of staff and had developed positive relationships with them. At lunch time we saw that staff sat and spoke with people. Staff assisted people and ensured they were using their mobility aids safely. Staff spoken with understood their role in providing people with compassionate care and support.

People told us they chose where to spend their time, where to see their visitors and how they wanted their care to be provided. We also noted that people were able to say when they wanted to be woken up in the

morning. All bedrooms at the home were being used for single occupancy. This meant that people were able to spend time in private if they wished to and could see their doctors, family and friends in private.

Relatives of people who lived at Carr Hall Care Home told us they could visit anytime of the day or week, there were no restrictions and they felt welcomed. This meant that people were able to continue maintaining important relationship in their lives. We saw that staff knocked on the doors to private areas before entering and ensured doors to bedrooms were closed when people were receiving personal care. We spoke with some people in their bedrooms and saw these had been made personal places with people's own belongings, such as photographs and ornaments to help them to feel at home with their familiar and valued things.

Staff had a good understanding of protecting and respecting people's human rights. We saw staff had received training which included guidance in equality and diversity. This would help staff to develop an awareness of human rights.

People had been supported to have access to advocacy service if they needed them. We spoke with the manager about access to advocacy services should people require their guidance and support. They had information details that could be provided to people and their families if this was required. This ensured people's interests would be represented and they could access appropriate services outside of the service to act on their behalf if needed.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection of Carr Hall Care Home in July 2016, we found the registered provider had failed to ensure individual or group activities were organised, undertaken or recorded. This was a breach of Regulation 9 of the Health and Social Care Act 2008 Regulations 2014 Person centred care. We also found that care records did not always contain accurate details to reflect people's needs and the care they required. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection the provider sent us an action plan telling us the steps they had taken to ensure that people were supported with activities and people's care records reflected their needs.

At this inspection we reviewed compliance against the breach of Regulation 9 and 17 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. We found some improvements had been made to the care files.

We looked at how the service provided person centred care. We found assessments had been undertaken before people were admitted to the home that would ensure the service was the right place to meet their needs. A person centred care plan had then been developed outlining how these needs were to be met.

We found the care plans were organised. They also included people's personal preferences, life histories, and aspirations. The majority of the people had care plans, which were supported by a series of risk assessments. We also noted charts were completed as necessary for people who required any aspect of their care monitoring, for example, personal hygiene, food and fluid intake, and positional changes in bed. However care plans did not have information about people's ability to make safe decisions about their care and support. The registered manager informed us that they consulted with people and their families regarding people's decisions however this had not been documented.

We found in the files that we looked at care records had not always been reviewed following significant incidents or changes in people needs. For example when people had suffered falls which had resulted in injuries or hospital admission or when people had lost a significant amount of weight. Care records had been reviewed irregularly, in some cases monthly and in majority of the cases every other month or two months. This meant that people were not assured that their health and care needs were reviewed regularly for any changes to allow timely action to be taken where required.

On our inspection visit on 09 October 2017, we found one out of 17 care files had been reviewed since our last visit on 11 September. We spoke to the registered manager who informed us that they had put plans in place to review one file per week and had scheduled to complete the work in 18 weeks. We expressed concerns regarding the time frame as this meant people would not be assured that they would receive the care that they required to meet their needs. We also raised concerns that staff would not have the correct guidance to support people safely. The same concerns had been raised by safeguarding professionals from the local authority. The registered manager informed us that they had struggled to find time to undertake this work as they were providing personal care. We spoke to the nominated individual who was the one of the owners of the home and they informed us they could not provide the registered manager with additional

support around this due to financial resource implications. This meant that people were at risk of continuing to receive care that did not reflect their needs which may expose them to risk.

The registered provider failed to ensure records were accurate, up to date and complete. This was a breach of Regulation 9 the Health and Social Care Act 2008 Regulations 2014.

People made positive comments about the way staff responded to their needs and preferences. Comments included, "I get a newspaper delivered here every day. I have it with a coffee and I am very comfortable here.", "I get my hair done every week. We don't have a lot of activities on but we have a singer every six weeks or so. I walk round for a bit of exercise. I've got a nice view of the garden from my bedroom window.", "My son visits every day, go out with him every now and then for lunch." Comments from professionals included; "Staff are knowledgeable about the residents and the medication; what it is for, how often taken and where to find further information about new medications." And; "Staff seem to be managing to stabilise one person's weight which suggests they are following the treatment plan effectively."

There were ongoing discussions about people's needs and well-being; this included regular staff 'handover' meetings between the registered manager, care staff and senior care staff (known in the service as officers).

We checked how people were involved in developing and planning for their care. The majority of the people could not remember whether they had been involved. The registered manager informed us that they would always consult with families and relatives to support in the designing of care plans. However they had not recorded how they had involved them.

The majority of the people we spoke with told us they had access to various activities and that there were things to do to occupy their time. The provider had employed one care staff who acted as activities co-ordinator for three days of the week. We noted a schedule of activities was posted on the wall in the home. However activity records showed that activities were not always offered. For example we found in some months people had access to only six activities in a month.

We observed doll therapy being used for people who lived with a dementia. Doll therapy is a practice where adults living with a dementia are provided with a doll to help ease anxiety, agitation and aggression. We saw that using doll therapy had a calming effect on some of the people who lived at Carr Hall Care Home. Staff showed compassion when supporting people in the use of doll therapy. However, people's care plans had not been updated to reflect the use of doll therapy. This is important to ensure staff had up to date guidance to support people to receive consistent care and support. We noted that further improvements were required to ensure people are supported adequately with activities.

We looked at how people were supported to maintain local connections and take part in social activities. We found people were encouraged to maintain local community links. People and their relatives told us they were fully supported with this involvement. Arrangements had been made for people's cultural and religious needs to be met. We saw examples where people were supported to with their cultural needs and had access to books and materials linked to their cultural and religious backgrounds. This had helped to ensure that people continued to have their cultural and religious needs met. People were facilitated to maintain contact with their families. People told us they could visit their family and friends whenever they wanted. This ensured that people could visit and spend time with their relatives and maintain family links.

We looked at how people were assured they would receive consistent, co-ordinated, person centred care when they used, or moved between different services. We found evidence of information that had been completed to facilitate information sharing when people moved between services.

We looked at how the service managed complaints. There was a complaints procedure advising people how to make a complaint; this included the contact details for external organisations including social services and the local government ombudsman and the Care Quality Commission. At the time of the inspection the service had not received any complaints. The registered manager informed us that they encouraged people to speak to staff if they have concerns and issues are resolved satisfactorily. People we spoke to informed us they could approach the care staff or the registered manager if they needed anything. One person told us; I have not had to complain about anything at all since I have been here." We saw people had made complimentary comments about the service. For example one person said, "Thank you name removed registered manager and staff for loving after [my relative] with care and compassion."

Inadequate

Is the service well-led?

Our findings

The service was led by a manager who is registered with the Care Quality Commission.

At the last inspection, we found the provider had failed to operate effective governance and quality assurance systems to monitor and improve the quality of the care and treatment provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, the provider sent us an action plan which set out the actions they intended to take to improve the service. At this inspection we found the necessary improvements had not been made and the provider had not followed their action plan to ensure compliance with the regulations.

During our last inspection there were significant breaches of regulations. At this inspection we identified all of the breaches of regulations had not been addressed and there were further breaches of regulations relating to seeking consent, maintaining the premises and a failure to submit notifications to the Care Quality Commission of significant incidents or events.

At this inspection we found that despite concerns raised at our previous inspection, action plans we received and a meeting with the provider, no significant improvements to the provision of the service had been made or sustained. This demonstrated the management systems at Carr Hall Care Home were inadequate. Following this inspection we concluded that there had been a further decline in the quality of the service and care provided and the provider had failed to make the necessary improvements required for the care and safety of people living at Carr Hall Care Home.

Following our visit on 08 and 11 September 2017. We asked the provider to complete a report on actions that they would take to address the concerns we had identified to ensure people's safety was maintained. We received a report with actions that the provider was going to undertake. We visited Carr Hall Care Home on 09 October to check whether some of the urgent actions had been completed and if risks had reduced.

We found that work had started to address immediate risks such as ensuring that the electrical installation is safe where water ingress was evident, reviewing of people at risk of choking, a review of safeguarding concerns and staff training. This ensured that risks to people were reducing. However we found a significant amount of work is yet to be completed and that the newly introduced systems and processes need to be embedded at the home. The service has also had additional input from the Lancashire Fire and Rescue service which had resulted in fire safety works being identified. We saw that these works were in the process of being addressed at the time of our visit on 09 October 2017.

Quality assurance processes were not robust. For example the provider's action plan regarding medicines management stated that, 'We will review our medication administration procedure after speaking with our pharmacy who does our training and audits.' The medicines management practices and our conversation with staff did not demonstrate or confirm they had their competency checked in this area. Therefore we could not be assured the provider understood the requirements of the regulation to ensure they were compliant.

There were no regular audits or monitoring taking place in relation to the management of medicines or infection control. The last medicines audit had been completed in October 2016. The manager told us the pharmacy had completed an audit. Due to the lack of regular medicine audits when errors or concerns had occurred, they were not identified in a timely manner and no action had been taken for a significant number of the shortfalls we found.
During our inspection visit on 09 October 2017 we found two professionals had visited to support with medicines management. The registered manager had been trained and provided with an action plan. They had not completed their own internal medicines audit. We could not be assured that they were able to do so and ensure that people received their medicines as prescribed.

We found that there was a lack of consistent quality auditing and governance processes. Formal audits had been completed in areas such as health and safety around the premises. However, the audits had not been carried out consistently and robustly. Only one infection control audit had been undertaken in 19 months. The health and safety audit carried out was not accurate or reliable. It had failed to identify the faults that we identified around the premises for example the lack of hot water in one bathroom, the radiator covers that needed replacing. Care files, staff personnel files, staff supervision and training records had not been audited regularly. We found issues during the inspection that could have been picked by regular formal audits. The registered manager had not provided oversight for the audits completed or developed any action plans on some of concerns identified.

At our inspection visit on 09 October we found an infection control audit had been undertaken. This audit identified shortfalls that needed attention, however no action plan had been written to identify what was required to be done, by who and when this should be completed. We also found a health and safety audit had been started however it was not complete and had no action plan. In their action plan that they submitted to us on 14 September, the nominated individual had advised that they would undertake monthly provider quality checks, however this had not been completed.

We looked at how the service provider's representative maintained oversight and governance on the service. They were visible in the service and maintained a close contact and regular communication with the registered manager. The nominated individual informed us that they visited Carr Hall up to three times a week. However we found no evidence to demonstrate how they had monitored and assessed the safety and quality of the service provided and assured themselves that the registered manager was ensuring that care provided was compliant with regulations. We saw evidence that the registered manager had communicated with the provider on concerns and issues that needed to be resolved such as staff training, and updated polices. However we found the service providers' representative had not always responded to the requests made in a timely and robust manner.

After the inspection visit on 11 September 2017 we had been advised through the action plan submitted by the provider that the provider would provide supervision to the registered manager however there was no documented evidence to demonstrate this had happened. We spoke to the registered manager who advised that they had sat down once with the provider and the external consultant since the inspection visit on 11 September. The nominated individual informed us that they would be visiting the home twice a week and check on the progress that the registered manager was making to ensure compliance however we found no evidence of how they had formally checked if the registered manager was addressing the areas of concern.

During the inspection visit on 09 October 2017 we asked the registered manager whether they continued to receive support from the care consultant. They informed us that they could contact the consultant whenever they needed via telephone or email however the consultant was not visiting them at the home. This was confirmed by the nominated individual. We concluded that the registered manager had not been

supported adequately by the provider to ensure they could address the concerns we found and ensure the compliance with regulations and that people could receive safe care and treatment.

We also found shortfalls relating to medicines management audits, staff supervision and appraisals, care file reviews and quality assurance checks, that the registered manager had been aware of and was within their remit to resolve however we saw that they had not taken necessary action to resolve the shortfalls.

We concluded that there was a lack of robust oversight and accountability by the nominated individual and the registered manager. We spoke to the owners who informed us they will introduce formal compliance checks on the service. After the inspection they confirmed that they had contracted an external consultant who had commenced formal compliance checks on the registered manager and the service at large.

The provider had failed to support care staff with the required skills and knowledge to undertake their roles safely. They had made a commitment during our meeting that staff would receive training. We found staff who had not received any training and some staff who had only received one form of training. We spoke to the nominated individual and the registered manager regarding the risks associated with lack of training for areas such as moving and handling, first aid and health and safety. They informed us that they had contracted a training company to support them however we found concerns regarding the credibility and validity of the training that was being provided to staff. Following our inspection the provider sent us confirmation demonstrating that they had booked an external validated trainer to provide training in a various areas.

We found the service had a number of policies relating to the provision of care and running of the service. However a significant number of the policies we reviewed were very brief and unable to provide staff with the required guidance on how to deliver their services in line with current legislation and best practice. We asked the provider to take action and we received confirmation that they had acquired up to date policies immediately after the inspection. We checked how these had been implemented during our inspection visit on 09 October and found staff had been asked to read some of the policies and had signed to demonstrate they had read them. A new package of policies had been delivered and gradually introduced into the service.

The provider did not have systems in place to enable them to learn from significant incidents such as accidents, or safeguarding concerns. Local safeguarding board protocols for reporting incidents had not been followed in majority of the cases. We found safeguarding incidents that had not been reported to the local authority as the service is required to do so. The provider acted immediately following this inspection to ensure risks to people were reduced. However we found the systems and processes at the service had not been designed to ensure a proactive and prompt approach was taken to assess, monitor and improve the quality of the service delivered. This would put people at risk of receiving poor care. There were concerns on the provider and the registered manager's understanding of the health and social care regulations and how to run effective governance systems that would ensure people received safe care and treatment.

The provider had failed to establish systems or processes to ensure compliance with the requirements of the regulations. There was a failure to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. This was a breach of regulation 17 the Health and Social Care Act 2008 Regulations 2014.

In the action plan we received following our inspection in July 2016, we were given assurances the provider could meet the legal requirements. For example, under safe care and treatment, the action plan stated, 'We have developed paperwork to record providers own internal investigation in regards to safeguarding

concerns, which will complete our audit trail.' At this inspection in September 2017 we found safeguarding incidents had not been reported to the local authority or to Care Quality Commission. We found staff did not have the guidance they needed and did not offer a consistent approach. These concerns were around the injuries to people who used the service. The management systems at the home did not identify these as concerns and the provider had failed to notify us of these events. At our inspection visit on 09 October we found they had reported concerns and there were policies that had been provided to care staff around the management of serious incidents.

We checked to see if the provider was meeting Care Quality Commission registration requirements, including the submission of notifications and any other legal obligations.

We found the registered provider had not fulfilled their regulatory responsibilities. They had not submitted statutory notifications to Care Quality Commission. For example, one person had suffered injuries which required hospital treatment. We also found the roof had been leaking for more than 12 months however we had not been notified. These incidents should have been reported to the Care Quality Commission as well as the local authority. Regulation requires providers should notify the Care Quality Commission of certain incidents. The intention of this regulation is to ensure that the Care Quality Commission is notified of specific changes in the running of the service, incidents involving people using the service, allegations of abuse, or incidents and events that threaten the smooth running of the service. This is so that the Care Quality Commission can be assured the provider has taken appropriate action. This also helps to ensure that the Care Quality Commission is able to undertake its regulatory duties effectively.

At our inspection visit on 09 October we found the registered manager had submitted one of the retrospective notifications. We received further retrospective notifications. However the provider and the registered manager needed to be prompted to submit the notifications which meant that we could not be assured that notifications would be submitted in the future without our involvement.

The provider had failed to make statutory notifications of notifiable incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People, visitors and relatives spoken with made positive comments about the leadership and management of the home. Comments included, "[Registered Manager] is very nice, very approachable and I can talk to her.", "[Registered manager] very much approachable. They listen to me and do what I ask. And, "She asks me about the home generally." A relative spoken with also told us, "I have no issues. I feel welcome as a visitor and just been offered a cup of tea. Overall the home meets her particular health needs very well."

Comments from staff regarding the leadership in the home were positive. Comments from staff included; "We have very good support from the [registered] manager and she listens." And; "I find her listening and approachable and I can go to her about anything."

Professionals who visited the service shared positive feedback. One professional told us "The manager or staff at the care home will also contact me with any queries…and there is a good working relationship and communication between the pharmacy and the care home. The manager is organised and is aware of the strengths of her team, ensures staff are sufficiently trained and I have always observed appropriate staffing levels during my visits."

We looked at how staff worked as a team and how effective communication between staff members was maintained. Communication was described by staff as being "good", however there were no regular staff meetings. The registered manager informed us that they always talk to staff anytime.

People were actively encouraged to be involved in the running of the home. We saw residents meetings were held and minutes of recent meetings showed a range of issues had been discussed. People commented on the quality of the service, food and their environment. Some changes had been made following suggestions at the meetings.

The service had a business contingency plan to show how they would deal with unplanned events that affect the delivery of regulated services.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission without delay of the incidents and significant events in the service including any event which prevents, or appears to the service provider to be likely to threaten to prevent, the service provider's ability to continue to carry on the regulated activity safely. Regulation 18 Care Quality Commission (Registration) Regulations 2009 -Notification of other incidents

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that that people who use the service receive person centred care and treatment that is appropriate, meets their needs and reflects their personal preferences. This was because care records had not been adequately reviewed and people were not provided with adequate activities. Regulation 9 HSCA RA Regulations 2014 -Person Centred care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that legal consent for care and treatment was obtained from people who used the service. Authorisations for deprivation of liberties had not been sought from relevant authorities-

	Regulation 11 HSCA RA Regulations 2014 Need for consent

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that care and treatment was provided in a safe way for service users because ; Risk assessments relating to the health, safety and welfare of people using services were not completed and reviewed regularly by people with the qualifications, skills, competence and experience to do so. People's medicines were not safely managed; Persons providing care or treatment to service users did not have the qualifications, competence, skills and experience to do so safely; They failed in ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;Risks of infections had not been adequately managed. -Regulation 12(1)(2)(a)(b)(c)(d) (g)(h)HSCA RA Regulations 2014 Safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure that All premises and equipment used by the service provider were suitable for the purpose for which they are being used, properly maintained, and be fit for purpose in line with statutory requirements. Faults and repairs had not been undertaken in a timely manner.- Regulation 15 (1) (a)(b)(c)(e) HSCA RA Regulations 2014 Premises and equipment

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure recruitment procedures were established and operated effectively to ensure that persons employed were of good character.Regulation 19 (1)(2)(3)HSCA RA Regulations 2014 Fit and proper persons employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that persons employed by the service provider in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2)(a)(b) HSCA RA Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure governance systems were robust and systems or processes were not established and operated effectively to ensure compliance. The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; The provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) The provider had failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; Regulation 17 (1) (2)(a)(b)(c)(d)(e)(f)HSCA RA Regulations 2014 Good governance

The enforcement action we took:

Enforcement action was taken by the Commission in light of the significant work needed within the home to improve the quality and safety of the service being provided. We added a condition to the service providers registration to prevent the Company admitting new people to the home whilst those changes took place.